24 March 2007
Chemist+Druggist
Weekly news for pharmacy
www.dotpharmacy.com

C+D

Pharmacy Champions

Pharmacy to compete for GP services

C+D poll reveals majority support for Society split

- COPD: the treatment options examined
- Independent prescribing: three case studies

NEW IN SMOKING CESSATION

THE POWER TO HELP THEM QUIT.[1-3]

- **A new class of oral prescription therapy with a unique dual action:**[1,2,4]
  - **Partial agonist** action: Reduces craving and withdrawal symptoms†
  - **Antagonist** action: Reduces the satisfaction associated with smoking†
- **Significantly higher quit rate vs. bupropion or placebo at 12 weeks**[1,2,5]
- **Favourable safety and tolerability profile in approximately 4,000 treated smokers**[6]

†Based on the Minnesota Nicotine Withdrawal Scale (MNWS).

CHAMPIX® Film-Coated Tablets (varenicline tartrate) ABBREVIATED PRESCRIBING INFORMATION - UK. Please refer to the SmPC before prescribing Champix 0.5 mg and 1 mg. **Presentation:** White, capsular-shaped, biconvex tablets debossed with "*Pfizer*" on one side and "CHX 0.5" on the other side and light blue, capsular-shaped, biconvex tablets debossed with "*Pfizer*" on one side and "CHX 1.0" on the other side. **Indications:** Champix is indicated for smoking cessation in adults. **Dosage:** The recommended dose is 1 mg varenicline twice daily following a 1-week titration as follows: Days 1-3: 0.5 mg once daily, Days 4-7: 0.5 mg twice daily and Day 8-End of treatment: 1 mg twice daily. The patient should set a date to stop smoking. Dosing should start 1-2 weeks before this date. Patients who cannot tolerate adverse effects may have the dose lowered temporarily or permanently to 0.5 mg twice daily. Patients should be treated with Champix for 12 weeks. For patients who have successfully stopped smoking at the end of 12 weeks, an additional course of 12 weeks treatment at 1 mg twice daily may be considered. Following the end of treatment, dose tapering may be considered in patients with a high risk of relapse. **Patients with renal insufficiency:** *Mild to moderate renal impairment*: No dosage adjustment is necessary. *Patients with moderate renal impairment who experience intolerable adverse events*: Dosing may be reduced to 1 mg once daily. *Severe renal impairment*: 1 mg once daily is recommended. Dosing should begin at 0.5 mg once daily for the first 3 days then increased to 1 mg once daily. *Patients with end stage renal disease*: Treatment is not recommended. **Patients with hepatic impairment and elderly patients:** No dosage adjustment is necessary. **Paediatric patients:** Not recommended in patients below the age of 18 years. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. **Warnings and precautions:** Effect of smoking cessation: Stopping smoking may alter the pharmacokinetics or pharmacodynamics of some medicinal products, for which dosage adjustment may be necessary (examples include theophylline, warfarin and insulin). Smoking cessation may result in an increase of plasma levels of CYP1A2 substrates. Smoking cessation, with or without pharmacotherapy, has been associated with the exacerbation of underlying psychiatric illness (e.g. depression). There is no clinical experience with Champix in patients with epilepsy. At the end of treatment, discontinuation of Champix was associated with an increase in irritability, urge to smoke, depression, and/or insomnia in up to 3% of patients, therefore dose tapering may be considered. **Pregnancy and lactation:** Champix should not be used during pregnancy. It is unknown whether varenicline is excreted in human breast milk. Champix should only be prescribed to breast feeding mothers when the benefit outweighs the risk. **Driving and operating machinery:** Champix may have minor or moderate influence on the ability to drive and use machines. Champix may cause dizziness and somnolence and therefore may influence the ability to drive and use machines. **Side effects:** Adverse reactions during clinical trials were usually mild to moderate. Most commonly reported side effects were abnormal dreams, insomnia, headache and nausea. Commonly reported side effects were increased appetite, somnolence, dizziness, dysgeusis, vomiting, constipation, diarrhoea, abdominal distension, stomach discomfort, dyspepsia, flatulence dry mouth and fatigue. See SmPC for less commonly reported side effects. **Overdose:** Standard supportive measures to be adopted as required. Varenicline has been shown to be dialyzed in patients with end stage renal disease, however, there is no experience in dialysis following overdose. **Legal category:** POM. **Basic NHS cost:** Pack of 25 11 x 0.5 mg and 14 x 1 mg tablets Card (EU/1/06/360/003) £27.30, Pack of 28 1 mg tablets Card (EU/1/06/360/004) £27.30, Pack of 56 0.5 mg tablets HDPE Bottle (EU/1/06/360/001) £54.60, Pack of 56 1 mg tablets HDPE Bottle (EU/1/06/360/002) £54.60, Pack of 56 1 mg tablets Card (EU/1/06/360/005) £54.60. Not all pack sizes may be marketed / marketed at launch. **Marketing Authorisation Holder:** Pfizer Limited, Sandwich, Kent, CT13 9NJ, United Kingdom. **Further information on request:** Pfizer Limited, Walton Oaks, Dorking Road, Tadworth, Surrey KT20 7NS. Last revised: 09/2006

Adverse events should be reported to Pfizer Medical Information on 01304 616161. Information about adverse event reporting can also be found at www.yellowcard.gov.uk

References: 1. Gonzales D *et al.* JAMA 2006; 296:47-55. **2.** Jorenby DE *et al.* JAMA 2006; 296:56-63. **3.** Tonstad S *et al.* JAMA 2006; 296:64-71. **4.** Coe JW. J Med Chem 2005; 48:3474-3477. **5.** Gonzales DH *et al.* Presented at 12th SRNT, 15-18th Feb, 2006, Orlando, Florida. Abstract PA9-2. **6.** CHAMPIX Summary of Product Characteristics.

CHA055a Date of preparation: Nov 2006

Pfizer

New oral prescription medicine

CHAMPIX® varenicline tartrate

C+D

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12

27

Cover: This week's Pharmacy Champion, Kate Molyneux. Picture: Neil O'Connor

Pharmacy targets role in medical services drive for deprived areas

Politics Industry welcomes drive as real opportunity for pharmacy

Ailsa Colquhoun

A government drive to add more medical services into deprived communities represents a real opportunity for pharmacy, industry representatives have said.

The Department of Health's plans will boost the number of GP surgeries and urgent care centres, as well as the availability of services such as out-of-hours care and smoking cessation.

PCTs will use alternative provider medical services contracts to boost medical services in areas poorly serviced by GPs.

Opportunities to improve local healthcare will not be restricted to GPs, said David Wood, executive director of the Independent Pharmacy Federation. "There are clear opportunities for pharmacy, for example in the provision of out-of-hours MAS services, or in condition-specific services. This is something we can work with forward thinking pharmacists in the independent sector to exploit, providing there is a level playing field on the commissioning side."

Multiple pharmacy operators also applauded the DH initiative, which has seen general practices and intermediate care services approved in Hartlepool, County Durham, Ashfield and Great Yarmouth.

Lloydspharmacy said the scheme could result in more than 150 million patient visits per year being switched from GP surgeries to pharmacies.

Justin Ash, Lloydspharmacy managing director, told C+D: "We're extremely interested in the announcement. The way we see the industry developing is increased co-location between healthcare professionals and pharmacy taking up a greater role in long-term condition management."

However, the Lloyds chief warned the government needs to ensure that communities are not threatened by the move.

He said: "The key to effective healthcare lies in ensuring services are available within the communities in which people live and work."

Could the drive for GP services in 'under-doctored areas' be good for pharmacy?

Who's in the APMS frame?

Boots: Boots has already indicated that it will be looking to explore such opportunities both nationally and locally, adding to the in-store GP surgery already open in Poole. Its director of healthcare, Alex Gourlay, said: "This review is good news. By offering more 'personalised' healthcare provision for the NHS, when and where people want it, we can make good health easier."

Private care providers: Care UK told C+D: "We operate a number of primary care services, and are interested in further developing our primary care services."

GPs: In areas such as Hillingdon PCT, doctors have already formed joint venture companies to provide APMS services. Commenting, Dr Hamish Meldrum, chairman of the BMA's GPs committee, said: "Existing GPs have a cost-effective track record of providing top quality services for patients. They must be allowed to bid for the new resources on an equal footing with newcomers such as private providers."

The supermarkets: Sainsbury's said it was still looking for potential sites, nearly a year after promising to test a GP surgery in-store.

Blair backs pharmacy in tailored services push

Prime Minister Tony Blair has highlighted pharmacy as one of the major pillars in his vision for public services to be tailored to patient needs.

In a policy review document launched this week, Mr Blair indicated that pharmacists could offer more enhanced services to improve access to care.

Chancellor Gordon Brown, who also attended the launch, cited the example of pharmacists being able to offer blood tests.

David Pruce, director of practice and quality improvement at the RPSGB, praised the initiative but emphasised that making use of pharmacists' skills would be key to its success in practice.

He said: "The use of electronic patient records will be key to helping ensure that there is co-ordinated care across GP surgeries, community pharmacies and hospitals."

The proposals, which included introducing more NHS 'walk-in' centres, were the first of a series of papers comprising the government's Building on Progress report. **TH**

Brown gives tax break to NRT products

Politics Chancellor cuts VAT on stop smoking aids

Chancellor Gordon Brown has outlined plans to reduce the tax on smoking cessation aids in his 11th budget, to contribute to efforts to make more people quit smoking.

Mr Brown said he would cut tax from 17.5 per cent to 5 per cent on NRT from July 1 to mark the introduction of the smoking ban in England. However, the reduction will only be in place until June 2008.

The move was broadly welcomed by ASH. Deborah Arnott, director of the health campaigning charity, said: "Reducing the price will encourage many more smokers to use these products, so making it more likely they can successfully quit. We congratulate the government on making this budget a quitters' budget but one year's reduction in the price of NRT is not enough. It should be sustained permanently."

Speaking at a seminar organised by the Consumer Council, prior to his budget announcement, Mr Brown said: "It's clear there are certain things we can do to give people the information and incentive to do what they probably want to do themselves. Should nicotine patches be cheaper? Should we tax cigarettes more? How do we stop smuggling?" **CB**

Ready for the next step: members of the Scottish Pharmacy Board urged MPs to give them greater healthcare responsibilities at their official launch at the Scottish parliament this week. The Royal Pharmaceutical Society's Scottish arm said the government must make better use of pharmacists' skills under its manifesto for Scottish pharmacy. The board also called for widespread pharmacist prescribing, appropriate access to electronic patient records and supporting pharmacists into the NHS team

Pharmacy backs split but opinion divided over Society's future

RPSGB Readers divided over adoption of royal college role

Tom Hawkins

Pharmacists have given their backing to the separation of the Royal Pharmaceutical Society's dual role, C+D can exclusively reveal.

In a poll of 89 readers, two-thirds said distancing regulation from the leadership role was positive for the profession.

However, respondents were less certain about the Society's intention to take on the role of a royal college. Fifty four per cent agreed that it should take on the leadership function but 46 per cent either disagreed or said they were unsure.

David Pruce, director of practice at RPSGB, said: "We are optimistic about persuading those who are unsure about the benefits of a royal college that it is the right way for us to go, once the detail of what it might look like begins to emerge."

The online survey, which is still open at www.dotpharmacy.com/whitepaper, also exposed differing views over the nature of membership. Just over half (53 per cent) favoured a voluntary model, while 28 per cent said it should be mandatory.

Opinion on the nature of membership was much clearer, with three quarters of respondents stating that full membership should be restricted to pharmacists.

There was also overwhelming support for a royal college to cover the whole of the UK. Just 10 per cent felt that pharmacists in Northern Ireland should not be part of the membership.

66% **Think separating the RPSGB's roles of regulation and leadership is positive for the profession**

18 Don't
16 Aren't sure

54% **Think the Royal Pharmaceutical Society should form the basis of a royal college**

24 Don't
22 Aren't sure

53% **Think membership of a royal college should be mandatory**

28 Don't
19 Aren't sure

74% **Think full membership of a royal college should be restricted to pharmacists**

16 Don't
10 Aren't sure

News in brief

Review extends focus?

PSNC claims the Galbraith review could extend beyond control of entry to include the national pharmacy contract framework and expects the formal consultation to start in late spring or summer. Anne Galbraith will unveil how she plans to improve the current arrangements at the end of March.

Shire and Servier breach

Shire and Servier have been admonished for breaching the ABPI Code of Practice.

Shire breached the code by failing to withdraw promotional materials for Calcichew-D3 Forte.

Servier was admonished for using inappropriate material when training representatives on how to target hospital staff. The Code of Practice Panel concluded that the material encouraged predatory behaviour.

NCSO update

The Department of Health and the National Assembly for Wales have agreed to allow NCSO (no cheaper stock obtainable) endorsements for the following items for March 2007 prescriptions – mefenamic acid capsules 250mg.

Kids consider pharmacy

More than 100 school children attended a Royal Pharmaceutical Society careers event that encouraged them to pursue a career in pharmacy. 'Science, Pharmacy and all that' invited students aged 14 to 15 from schools local to the Society's headquarters to take part.

Welsh scrutinise oxygen

The Welsh Audit Office report into the home oxygen service in Wales is expected to be published in the summer. It is likely that the Welsh Assembly's Audit Committee will then wish to consider the report.

Correction

The news story in last week's issue saying that Roche was to take Nice to court over its draft appraisal on erlotinib (Tarceva) was in error. The company is appealing to Nice following its recent decision. C+D apologises for the error.

Novartis eyes up direct distribution route

Industry Drugs firm keen on the potential of Pfizer's changes

Wesley Yin-Poole

Novartis is considering following Pfizer's lead and selling its products direct to pharmacy.

The Swiss drug maker said it was "interested in understanding the potential" of the DTP model.

It has sent out letters to tender to a number of stakeholders on the issue. Novartis intends to consult community pharmacists before making any decision, although it has not yet developed a plan on how it will do so, the company said.

John D'Arcy, chief executive of the NPA, voiced concerns over Novartis's move. He said: "The concern is this is another step in the direction of nailing down the wholesalers. You put at risk the value-added services wholesalers provide. If you lose turnover, at what point do you pull in the reins?"

BAPW executive director Martin Sawer also criticised the move. He said: "This is another proposed commercially-driven piecemeal change to a robust and flexible model which is delivering for the NHS."

Wholesalers are open to "constructive changes" to the current NHS supply model, but any adjustments must be agreed by all stakeholders first, Mr Sawer added.

Stumbling block: Novartis says supply route changes could boost relationship with pharmacy, but BAPW claims proposals are "commercially driven"

A spokesperson for Novartis said the move was triggered by pharmacy's increasing role in the delivery of services.

"We feel we need to get closer to pharmacists and we are exploring whether this is the way to do it."

Novartis's review follows moves by other drugs giants to take greater control over the supply of their medicines to pharmacies.

Pfizer launched a direct to pharmacy delivery service this month and AstraZeneca is currently reviewing the way its drugs are distributed in the UK.

Phoenix predicts more DTP schemes

Industry Phoenix writes to customers with ordering proposal

Phoenix has told its customers that it is introducing a system that can place orders on their behalf for direct to pharmacy distribution schemes.

Phoenix deputy chairman David Cole said in a letter issued last week: "It is now entirely possible that we shall see a proliferation of manufacturer schemes, using a different combination of distributors, all with different administration processes."

He added: "We are immediately introducing a new service by offering to continue to receive all of your order lines and then undertake to relay those order lines from an agreed product portfolio to the appropriate distributor."

• AAH Pharmaceuticals says it has met and agreed with Pfizer "what needs to be done to address the problems some customers have faced with TPOS although the system works well for the vast majority of users". **WYP**

UniChem acts on Rowlands' teething issues

Industry Supply issues to be tackled in a "timely and efficient" way, says wholesaler

UniChem has said it is working to address reports of teething difficulties around the supply of Pfizer products to Rowlands pharmacies.

Kenny Black, managing director of Rowlands, owned by rival wholesaler Phoenix, claimed that there had been a small number of issues around deliveries.

The retailer also had not signed up to the direct to pharmacy scheme before its launch this month, Mr Black added.

A spokesperson for UniChem revealed it was "aware of the concerns cited by Mr Black" and has been working with Rowlands to "rectify any issues in a timely and efficient manner".

UniChem reported 99.3 per cent of deliveries had been made on time and in full since it became the sole distributor of Pfizer medicines. **WYP**

Pfizer responds to you

C+D readers quiz Pfizer head of trade David Watson on the launch of direct to pharmacy drugs supply

Andrew Hales, Andrew Hales Pharmacy, Cardiff: "Will Pfizer look to review cut off time for deliveries as my new slot under direct to pharmacy causes serious disruption to patients?"
DW: "We didn't say we would match current cut off times. You have to remember it depends on the distance the pharmacy is from a particular depot. We believe our cut off times are equitable, but we are already in the process of looking at them."

Gurminder Sall, Jeeves Chemist, Iver Heath, Buckinghamshire: "Will Pfizer be looking to streamline the extra paperwork generated by its distribution model?"
DW: If you look at the overall admin burden of pharmacists, I don't think it's significant for the running of a business. Longer term, we do need to look at this. There are all sorts of clever IT things we can do, from cash collection to order management."

George Romanes, GLM Romanes Pharmacy, Duns, Berwickshire: "Why has it taken a fortnight to get my Pfizer account live?"
DW: "There are an exceptionally small number of cases where we just can't identify who is requesting the order. There are regulatory reasons why we have to make sure a pharmacist is a pharmacist before we can sell products to them. Since we have gone live the turnaround has been very quick. If some people missed the deadline we set then that may have resulted in a slight delay. But people having to wait anything but a couple of days is an isolated experience."

Shiraz Jiwani, Old Coulsdon Pharmacy, Surrey: "What do we do if there is a sudden surge in demand for a particular type of product and UniChem runs out?"
DW: "We always keep emergency stock, what we call buffer stock, in our main warehouse in the UK, of the critical medicines in our portfolio. We have a large supply of medicines in the UK. I think we're very good at managing supply of products."

News in brief

MHRA warns on BZP

The MHRA has warned that benzylpiperazine (BZP) pills are dangerous and vendors selling them to the public may be prosecuted.

The MHRA has issued a statement that BZP can cause agitation, vomiting, abdominal pain, seizures, abnormal heart rhythms, diarrhoea, allergic reactions and fever. In rare cases users suffer serotonin syndrome, which can result in death.

Inactivity drain on NHS

Physical inactivity costs the NHS more than £1 billion a year, researchers at the Department of Public Health at the University of Oxford have reported in the Journal of Epidemiology and Community Health. Inactivity also caused around 3 per cent of disability-adjusted life-years lost in the UK.

Faster drug approval

Welsh health minister Brian Gibbons is launching a fast track drug approval system in a bid to provide patients with the most up to date treatments.

The Welsh approval rules, to be operated by the All-Wales Medicines Strategy Group, will be wider than those operated by Nice. Dr Gibbons said it will appraise 32 medicines a year – four times the current number; will "complement" Nice; and would not usually move if Nice intends to publish a final appraisal within 18 months.

5,000th technician

Jonathan Ainley, a hospital pharmacy technician, has become the 5,000th technician to register with the Royal Pharmaceutical Society. Of the 5,000 pharmacy technicians who have now voluntarily registered, around 65 per cent work in community pharmacy; 25 per cent in hospitals; and six per cent in primary care. Eighty five per cent live in England.

NPA climate change action

The NPA has signed up to the Trade Association Forum's declaration to tackle the causes and effects of climate change. Initially, the NPA will incorporate greenhouse gas reduction and sustainable development measures in its strategy. It will also encourage members to reduce emissions.

Health agenda helps Lloyds' revenue rise

Retailing Pharmacist as healthcare provider tactic boosts turnover

Max Gosney

Pushing pharmacists' potential as healthcare providers helped Lloydspharmacy boost turnover by 11.6 per cent to £1.5 billion in 2006, according to managing director Justin Ash.

The retailer had reaped the rewards of gearing up pharmacy staff to take advantage of the contract, the Lloyds chief told C+D.

"There's been a cultural change. We have really focused on getting pharmacists to see themselves as broad-based healthcare providers. This has been a commercial success, generating customer loyalty and a demand for medical electrical products," he said.

Lloydspharmacy recorded a 67 per cent rise in healthcare services including medicines use reviews, smoking cessation and minor ailment services in 2006, end of year results revealed.

The company also carried out more than one million diabetes tests and 417,000 blood pressure checks.

A commitment to combating chronic conditions will continue in 2007, added Mr Ash. "We're looking at introducing a healthy heart check in pharmacies this year. We need to be offering accessible treatment to the diseases that affect a broad base of the population."

Lloydspharmacy could introduce further automation to support staff in offering healthcare services, Mr Ash added. "We want to make dispensing easier for pharmacists so it frees up their time to provide services. Automation is one way of doing that."

The comments follow the trial of a pharmacy robot at a Lloydspharmacy branch at Broxburn, near Edinburgh.

Lloydspharmacy's parent company Celesio also announced its end of year results this week. The German healthcare giant claimed an extension of its pharmacy network fuelled a rise in pre-tax profit from €554.5m in 2005 to €590.1m in 2006.

Justin Ash: "cultural change" has been a commercial success

Lloydspharmacy results lowdown:

- Turnover up 11.6 per cent to £1.5bn.
- Lloyds adds 29 pharmacies to reach 1,556 outlets.
- Prescription business up 12 per cent to £122m.
- 308 pharmacies co-located with GP surgeries.
- 34.5 per cent market share for MURs.
- 126 refits, extensions and relocations in 2006.

Perfect fit: students and staff from the School of Chemical Sciences and Pharmacy at the University of East Anglia celebrate receiving full accreditation status for the MPharm degree. The visiting team from the Royal Pharmaceutical Society complimented the School on the enthusiasm and professionalism of its students. UEA's School of Pharmacy had its first intake of students in 2003; there are now more than 20 staff and more than 300 undergraduates

Smoking support extends to South Wales

Wales Successful pilot leads way for extension of smoking cessation programme

A pharmacy-led smoking cessation programme will extend to South Wales after a successful pilot in the north of the country helped 218 customers attempt to quit.

Pharmacies in Wrexham, Conwy and Gwynedd will take up the service following a positive response to the scheme in Denbighshire, according to the NHS's All-Wales Smoking Cessation Service.

The organisation plans to train 250 pharmacists to provide smoking cessation support by the end of 2007. The Welsh ban on smoking in enclosed public spaces is introduced on April 2.

Peter Jones, chief executive for Community Pharmacy Wales, said: "We support the rollout of smoking cessation schemes through pharmacy." **CB**

New Care Stingose®

The antidote to bites and stings from down under is now available over your counter

Why buy the same old story when you can now sell the antidote? Care Stingose® Spray is the only antidote for bites and stings. Unlike most remedies which just relieve the symptoms, Care Stingose works on the cause as it neutralises the venom - so the sting goes. Care Stingose relieves the pain and reduces the effects of bites and stings from wasps, bees, mosquitos, nettles, jellyfish and stinging plants - which is why it became Australia's No.1 selling bites and stings treatment.

For more information please call 01484 848200 or contact your local sales representative.

All the care you need.

Presentation: Pump spray for topical application. **Contains:** Aluminium Sulphate 20% w/v, Sodium Lauryl Diethoxysulphate Fragrance SLS 9004 and Purified Water **Indications:** The antidote for stings and bites Relieves pain and reduces the effects of stings and bites from insects, animals and plants. **Dosage and Administration:** Adults and Children Spray immediately onto the affected skin. Re-spray if necessary **Contraindications:** There are no contra-indications to Stingose. Some individuals may have limited skin reaction of short duration, but these are rare **Warnings and Precautions:** Stingose should not be applied to the eyes The skin must not be pre-treated with methyl spirits or alcohol, as this will reduce the activity of Stingose **Pregnancy and Lactation:** No effects known **Side Effects:** None known **Legal Category:** GSL **Licence Number:** PL 13227/0001 **Pack Size:** 25ml **Retail Price:** 25ml £3.99 inc VAT **Trade Price per Single:** 25ml £1.88 exc VAT **Licence Holder:** Wellvalue Ltd 1 Park Place Canary Wharf London, E14 4HJ **Manufacturer and Distributor:** Thornton & Ross Ltd, Linthwaite, Huddersfield, HD7 5QH **Date of Preparation:** 12.03

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Your letters

Reduced discounts make clawback more painful...

Independent pharmacy contractors find themselves in a no win situation when the new tiered discount structure from Pfizer is set against the government clawback.

Only 8.5 per cent off for independents against 11.5 per cent for the chains not only means they are effectively subsidising the nationals but, with a clawback of up to 11.5 per cent, they will also be losing money on every Pfizer product they dispense – and Pfizer products represent around 20 per cent of a pharmacy's total ethical spend.

We have already suffered increased pressure on margins from PPRS and the loss of oxygen and category M generics. Effective intervention is needed.

We are therefore urging PSNC to negotiate with the DH a reduced clawback for independent pharmacists as a matter of utmost priority.

We want parity restored, especially as Pfizer made it clear at a meeting with Cambrian Alliance that it will not deal with the buying groups that represent the vast majority of independents and that help them to compete with the multiples.

We do not agree with the argument, too readily accepted in our view by PSNC, that their costs are higher. What they have in fact is economies of scale and buying power. Their preferential Pfizer discount will allow them to invest rapidly and be first to the market with new services, giving them a head start with patients.

The government is penalising community pharmacists for their thrift and entrepreneurial skills as buyers over many years, shrewdness that has saved the NHS millions.

Their role in helping to contain the national drugs bill has never been given any real acknowledgement or reward. But it must realise that only a competitive and dynamic market can deliver the cash-saving shift to primary care, with its emphasis on local provision, it is so anxious to

achieve. For such a market to flourish the viability of the community pharmacy network is critical.
Mark Griffiths, chairman, Cambrian Alliance

...Pfizer says scheme reflects current market practice...

I am writing in response to Cambrian Alliance's letter (above).

Following consultation with the DH, and discussions with the profession via PSNC, we have structured our discount scheme around a series of incremental increases according to volume of purchases made on eligible products.

In this way our discount scheme reflects current market practice and the structure of funding in the pharmacy contract.

We believe the Pfizer discount scheme should not negatively impact pharmacy purchase profit and understand that it is likely that a

further invoice enquiry will commence for England and Wales in late March or April 2007.

Changes in discount, driven by either Pfizer discounts directly or by wholesalers changing their discounts in light of the removal of Pfizer prescription medicines, would be picked up in an invoice enquiry and reflected in changes to clawback.

PSNC's website says "the funding package for 2007-08 will therefore ensure that there is no detriment to contractor funding as a consequence of the changes".

Cambrian Alliance recognises that there was a loss to pharmacy income as a result of the last price reduction of 7 per cent in PPRS. It may be obvious, but Pfizer, along with all other major manufacturers, also had to absorb a price cut of this level – the knock-on effect of which is reduced margins throughout the industry.

Finally, it is not the case that we will not deal with the buying groups. Having recently moved to a direct relationship with pharmacy, we will continue to review our commercial plans and see no reason why we wouldn't explore commercial arrangements with buying groups across the UK, where we can identify areas of mutual benefit.
David Watson, head of trade, Pfizer

...PSNC backs contractors

The new national pharmacy contract secured a level of protection for contractors against inevitable and increasingly frequent market shocks through the provision of guaranteed funding.

This protection was not available under the previous arrangements. PSNC remains concerned about any damage arising from Pfizer's actions to the traditional supply chain that reduces the valuable support that full liners in particular provide to independent contractors.

One of PSNC's strategic priorities is to ensure that contractors receive the funding they are entitled to. The invoice enquiries used to monitor the availability of buying profit will capture any effects arising from Pfizer's new terms.

PSNC has opened discussions with the DH on clawback. The current scale, which stretches from 5.63 per cent to 11.5 per cent, is based on both brand and generic margins.

A circa £700 million pa total clawback sends a very clear signal to the DH about the effectiveness of community pharmacy's purchasing ability. It is worth emphasising that the guaranteed buying profit of £500m is payable regardless of the prevailing rate of clawback.
Mike Dent, head of finance, PSNC

AAH defends third party ordering system

It was reported that Pfizer and UniChem are meeting AAH to "resolve technical problems with the Coventry-based wholesaler's third party ordering system" (C+D, March 17, p4). This is not the case. AAH's third party ordering system does not have technical problems. A handful of customers did face problems in the first few days. It was not because of any incorrect configuration of the TPOS system by AAH. It can be resolved by customers getting a usable PMR ID from UniChem.

It is important your readers understand the facts. In the first week, as the article states, more than 3,000 customers used our system successfully to place more than 10,000 orders. Usage continues to grow successfully. The system is straightforward and we have had positive feedback from customers. I trust this will reassure customers.
Steve Dunn, group managing director, AAH

David Watson responds...
Pfizer is aware that AAH has recently offered a number of independent pharmacists the use of its TPOS system to route orders for Pfizer products. We are aware of initial problems in using this system and Pfizer and its logistics service provider, UniChem, are working to identify and resolve any issues as quickly as possible. In some cases, this has required UniChem to issue additional PMR IDs to customers choosing AAH's TPOS system. Pfizer is confident it is able to take orders from the majority of PMR systems.

We recommend pharmacists place orders directly with Pfizer, through UniChem, as previously notified. For information on ordering systems, contact Pfizer on 0845 608 8866.

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Pharmacy Champions

Pharmacists leading the way

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What has she done?
Set up a smoking cessation service

What have you set up?
The smoking cessation service is funded by the Warrington stop smoking service and the PCT. I attended two training evenings run by the PCT. They also like you to go to at least one update study session each year.

What has been the high and low point of setting up the service?
The high point has been the success of the service. I was initially involved in the pilot scheme in the Warrington area. About five pharmacies took part, but we were the only pharmacy to get the service up and running. Because I'd been successful, I was invited to get involved in the training of other pharmacists when the scheme was rolled out across a wider area. I also gave a talk at the training evening to help another pharmacist who wanted to set up the service.

The low points are when people don't turn up for their appointments. When you set time aside for people it can be frustrating when they don't arrive. You just think to yourself that someone else could have benefited from that appointment.

How have the patients and GPs reacted?
The local GP practice loves the service and actually invited me to run two sessions a week at the surgery. Other surgeries also recommend me to their patients.

The patients find the service convenient as there is easy access to it and appointments are flexible. They can call in or ring the pharmacy at any time if they have problems. The regular customers find the service a bit less 'clinical' than visiting their GP, especially when they are familiar with the pharmacy and staff here.

Do you have any advice for others?
You need to plan ahead and be prepared. I wrote out a session-by-session plan of what I had to do. You need to look at your business as a whole and work out the quieter times where you could book in appointments. Be adaptable. Sign up people for collection and delivery from local surgeries so that you can plan your workload. Utilise the skill mix of all your staff – I have a qualified accuracy checking technician, which helps a great deal.

Why do you think you have been successful?
I think just getting stuck in and going for it worked. I was very nervous at first but after a few consultations I relaxed into it. Good advertising helps – I used posters, visited the local surgery and the Warrington stop smoking service notified other surgeries of how people could access the service. Training the counter staff on how to sell the service is also a good idea. The scheme grew a lot through word of mouth.

Has offering the new service given you greater job satisfaction?
You get a kick when someone successfully gets to the end of the course. The patients are generally really appreciative of the time you've given them. I've had cards, chocolates and flowers from patients to say thank you, and I still have regular patients who come into the pharmacy two or three years down the line really proud of themselves. They shout across the counter to me: "Kate, still not had one!"

You also get to know your patients a lot better and they feel more relaxed asking you for advice on other matters.

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Comment from the editor

Pioneers needed to bring government vision to fruition

Pharmacy has never featured so prominently in the national press.

As if the Pfizer distribution deal and the Alliance Boots takeover were not enough, pharmacy was once more in the media spotlight this week when no less a double act than the Prime Minister and the chancellor unveiled the government's review of public service policies for the next 10 years.

As part of the now familiar rhetoric on NHS modernisation, pharmacy was highlighted (albeit briefly on page 47 of the 87-page review document) as a sector that could contest the provision of diagnostic services with GPs.

Not only would PCTs be able to commission such services, but pharmacies could "establish an individual's eligibility for tests and record the results using the newly introduced electronic patient records", says the document. It sounds wonderful: commissioned services and ready access to patients' records, but can pharmacists who have long grown tired of listening to empty promises have faith in this vision?

The reality is that for many PCTs, faced with the burden of ensuring financial balance, pharmacy remains a low priority, a fact ably demonstrated by last week's Conservative Party survey of PCTs that found nearly half of all trusts had cut funding allocations for smoking cessation services.

And if such a valuable intervention as smoking cessation is failing to attract support from PCTs, what hope is there for Tony and Gordon's wish to see more services in pharmacies? (Incidentally, are they aware that diagnostic testing in pharmacies is not new? Some one million people, for example, have taken advantage of Lloydspharmacy's free diabetes screening test since 2003 alone, according to the company's website.)

However, despite the uphill fight that pharmacists face in securing PCT funding, there are some real positives emerging for the sector. C+D's article on prescribing (pages 27 to 30) features three pharmacists as they look to qualify as independent prescribers.

Whether offering services for example in asthma, diabetes or hypertension, it will be pioneers such as these who will show PCTs that pharmacy can be an extremely effective way to help them meet national health targets. And perhaps Tony and Gordon will realise that they have to take tough action to ensure community pharmacy is allowed to deliver what everyone now knows it can offer.

What hope is there for Tony and Gordon's wish to see more services in pharmacies?

Lambeth outlook

The times they are a-changin'

The government's White Paper presents a real opportunity for the RPSGB to evolve, says Hemant Patel

Most C+D readers will by now either have read or heard about the recent government White Paper on the regulation of health professionals.

The paper proposes the creation of a General Pharmaceutical Council (GPC) to carry out regulatory functions currently undertaken by the Society. It also calls for a 'Royal College' role to provide professional leadership.

I know there are many community pharmacists who have always perceived the Society to be primarily a regulator and who believe this change cannot come soon enough. There will be others who oppose the idea and also those who think "why should I care?" I want to use this column to explain how important the proposed changes in the White Paper are to the future of pharmacy and also to highlight how the Society is actively engaging with the process on behalf of you and the profession.

The Society has a proud 166-year heritage and it is important to understand that the changes are not being proposed because the organisation has done anything wrong. The Society has carried out its dual role effectively for many years, helping to develop and support the pharmacy profession and also protect the public.

But times have changed and the Society, as a regulator, is not immune from the issues raised by high profile cases such as Shipman. Pharmacy across all sectors is changing fast and new clinical roles are seeing the profession take on increased and direct responsibility for patient care. These responsibilities require new ways of regulation and professional development in order to support future development.

I see the changes proposed in the White Paper as a real opportunity for the Society to evolve its role, with the organisation uniquely placed to develop into a Royal College-type body. If developed and implemented in the right way, the proposals in the White Paper will lead to stronger leadership for the pharmacy profession while ensuring greater patient safety.

The Society is very much involved in the Carter working party that has been appointed by the government to draw up initial plans for the GPC and a Royal College. Working with the working party, the Society believes that the following are necessary to underpin the formation of the GPC and proposed Royal College:

- The new arrangements ought to improve on current structures, leading to both improved public and patient safety and stronger professional leadership for pharmacists.
- The transition to a General Pharmaceutical Council and the possible establishment of a Royal College needs to be properly managed and resourced.
- Structures for both regulation and professional leadership need long-term financial sustainability.
- Strong and transparent governance arrangements will be needed for both the regulation and professional leadership of the pharmacy profession.
- The pharmacy profession and other stakeholders ought to be fully considered and consulted during the process of change.

The Society will be doing all it can to keep consulting its members on these changes and to take feedback on board from all its key stakeholders.

Hemant Patel, FRPharmS, is president of the Royal Pharmaceutical Society

Xrayser

Keep pseudoephedrine in the pharmacy

History has shown us that most attempts to restrict the availability of recreational drugs have proved unsuccessful, if not counter-productive. Prohibition of alcohol in the USA created a huge market for organised crime which, when the law was repealed, simply switched its focus to the potentially more lucrative demand for drugs.

A hundred years ago cannabis, cocaine and morphine were readily available from your high street pharmacist and the only warning deemed necessary was a straightforward *caveat emptor*. Controls on drugs such as arsenic and cyanide have undoubtedly saved lives, but clumsy attempts to limit availability of recreational drugs such as cannabis and heroin may have done more harm than good.

While the MHRA is not proposing to ban sales of pseudoephedrine and ephedrine, the retrograde reclassification from P to POM (C+D, March 17, p5) will cut use to virtually insignificant levels. I can't imagine many GPs using their precious drugs budget on drugs such as this when they've worked so hard to convince patients of the nature of self-limiting viral infections.

I don't know how much crystal meth has been 'homemade' using these ingredients but I bet it's insignificant in terms of the nationwide scale of drug misuse. Crystal meth is simply unheard of in my locality so there is no market for the stuff around here. Local teenagers are more than happy to get out of their head on legal, and therefore 'safe', alcohol.

If there is money to be made here, these 'kitchen chemists' will simply nip over to France for the day to stock up on Le Sudafed. And if organised crime really is involved it will simply make a wholesale purchase, or heist. Suddenly this drug sounds more attractive, prices go up, more criminals get involved and voilà – another popular recreational drug for parents to worry about. But will it recruit new consumers to the illegal drugs market or simply encourage users of other drugs to switch or even mix?

This short-sighted measure will simply deny a lot of people a moderately useful medicinal drug while simultaneously boosting illicit drug use and associated crime. Whatever happened to the 'expert patient' and 'encouraging self-care'? And of course my increased tissue sales for all those patients with untreatable runny noses will not compensate for the healthy margin I've lost on OTC medicines.

Let's keep medicines in safe hands – the pharmacist, not the drug dealer.

A breath of fresh air for smokers

The lack of an effective joined-up approach to healthcare funding often limits the effectiveness of good healthy ideas. The forthcoming smoking ban is a case in point.

When the government passed a law banning smoking in enclosed public places it should have simultaneously allocated some funding to help all these potential quitters to give up. Instead, via reorganisation in PCT funding, budgets for local smoking cessation services are being frozen at a crucial time (C+D, March 17, p5).

The government could be right if it expects the ban alone to encourage some smokers to endure a cold turkey quit attempt. But others will simply join the huddles in office doorways and the drop in employees' output must have an effect on the country's GDP. There's a false economy if ever there was one.

Pubs will simply invest in their beer gardens and patio heaters and this outdoor lifestyle/work dodge could attract new smokers, rather than encouraging quitters.

Your views

No place for complacency

I feel I must disagree with my esteemed colleague Tony Schofield when he says that "... crystal meth is not the problem that heroin is..." (C+D, March 17, p5). I have one word to say – *yet*.

Pseudoephedrine/ephedrine's structure is the same except for the arrangement of the various groups in space; they both have an OH group on the first carbon atom of the propyl group attached to the phenyl moeity. This OH group needs reducing, removing the oxygen, replacing it with hydrogen, and bingo! Methamfetamine.

This process is described in great detail in Karsch's Pathology of Drug Abuse pp238-239 (3rd ed CRC Press 2002), and needs red phosphorous to carry it out. No doubt it is on the internet too! "Where would you get red phosphorous from?" I hear you ask. Well if organised criminal gangs can get hold of mercury and cyanide compounds to make other illegal drugs then they can get hold of red phosphorous.

The process is, according to Karsch, very simple and the equipment needed to make it can be carried in a suitcase. Many states in the USA have restricted the supply of ephedrine and pseudoephedrine because it is so easy to make methamfetamine – Mexican 'superlabs' are turning out tonnes of the stuff (Karsch, p239).

The process is, says Karsch, very simple and the equipment needed to make it can be carried in a suitcase

As to pseudoephedrine's source, all you need is an army of shoppers to visit pharmacies *en masse*, each one just making a single purchase of Sudafed, and overnight you have the raw material. An entry in a register à la Phensedyl would not pick this up – you would not remark on selling a single pack of Sudafed.

It is much harder to process opium into heroin, which then has to be smuggled in: methamfetamine is home grown. The sooner pseudoephedrine is made a POM the better.

Bob Dunkley MRPharmS, Leeds

"I'm on 40 a day,
I'm too old to change"

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C+D Clinical

Treatment of COPD

In the second of two articles on COPD, we look at how management must take account of each individual's symptoms and disability

Key points

- Stopping smoking is the single most important intervention.
- Bronchodilators are used in a step-up approach, starting with a short-acting beta$_2$ agonist or ipratropium, then both combined if necessary.
- Treatment then moves on to long-acting beta$_2$ agonists or anticholinergics, finally adding methylxanthines if symptoms are not controlled.
- Corticosteroids may be needed in frequent exacerbations.
- Mucolytics help sputum clearance.

Anna Murphy

Although chronic obstructive pulmonary disease (COPD) has no cure, various treatment options are available. Appropriate management can make a major impact on symptoms and quality of life, even for patients with severe disease. This article provides an overview of the approaches to managing COPD (see C+D Pharmacy Update last week for causes, signs and symptoms).

COPD affects every patient differently and should not be regarded only as a disease of the lung. Patients experience a variety of symptoms reflecting the multi-dimensional nature of the condition. Some patients may be troubled by breathlessness, others may develop ankle swelling and yet others may have a productive chronic cough. The management of an individual patient should be guided by the symptoms and disability that

The College of Pharmacy Practice

This course (module 1400), in association with multiple choice questions being published in C+D April 7, provides one hour's continuing education

CPD

This article can help in the following CPD competencies: C1a, C1c, C1d, C2a, C2d, C3e, G1a. See www.tinyurl.com/194zu

Reflect

What do you know about the step-up approach to using bronchodilators in COPD? When should corticosteroids be used? What would you recommend to help prevent repeated hospital admissions?

Plan

This article stresses the importance of managing COPD symptoms according to each individual patient and the need to monitor treatment. The various drugs used are described, as well as steps that can be taken to prevent frequent exacerbations.

Appropriate management of COPD can greatly improve symptoms and quality of life, even in severe disease

they experience. At different times in the disease's progression, the patient may experience different symptoms and any drug treatment may need to change to reflect this.

The Nice guideline on COPD published in 2004[1] describes eight broad problem areas, each of which may require drug therapy:

- smoking cessation
- breathlessness and exercise limitation
- frequent exacerbations
- respiratory failure
- cor pulmonale – changes in circulatory system of the lungs leading to the dilation of the right ventricle (acute) or its hypertrophy (chronic)
- weight loss
- chronic productive cough
- anxiety and depression.

Pharmacological management

Used correctly and in a logical sequence, various drugs can prevent and control COPD symptoms, reduce the frequency and severity of exacerbations, and improve lung function and quality of life. Used unwisely, drugs may have little therapeutic effect, only increasing the burden of the disease on the individual and adding to economic costs.

The overall approach should be to assess each individual's symptoms and response to various treatments. Treatments should be monitored closely and adjusted accordingly. Traditionally, the response to drug therapy was assessed by reversibility testing using a spirometer. While spirometry remains essential for confirming the diagnosis of airflow obstruction, reversibility testing is no longer routinely recommended to guide drug therapy. Effectiveness of therapy should be assessed by a variety of measures, not just lung function.[1]

Patient's symptoms, activities of daily living, exercise tolerance and exacerbation rate should be measured. If a treatment has no impact on these the medication should be reviewed with the aim of withdrawing anything that has little therapeutic benefit. Box 1 above indicates the type of question that can be used to help assess the effectiveness of medication.[2]

Bronchodilators

Although COPD is characterised by substantially irreversible airflow obstruction, many patients show clinical benefits to bronchodilators.[1] Bronchodilator drugs improve breathlessness by reducing airway smooth muscle tone and increasing airway calibre. They also lead to a reduction in pulmonary hyperinflation, increase mucociliary clearance and improve respiratory muscle function, which probably explains why clinical benefits may be seen without clear changes in the patient's lung function.

There are three classes of bronchodilators:

- beta$_2$ agonists (short-acting and long-acting)
- anticholinergics (short-acting and long-acting)
- methylxanthines.

Patients with COPD should have their inhaled treatment stepped up according to their symptoms – see www.tinyurl.com/2zskos.[1]

Box 1: Questions to assess the effectiveness of medication[2]

- Has your treatment made a difference to you?
- Is your breathing easier in any way?
- Can you do some things now that you could not do at all before the treatment, or do you do the same things but faster?
- Can you do the same things as before but are now less breathless when you do them?
- Has your sleep improved?

Short-acting beta$_2$ agonists

Short-acting beta$_2$ agonists (SABA), such as salbutamol and terbutaline, are the most widely used bronchodilators for COPD. They relax airway smooth muscle and reduce breathlessness. The onset of action is slower than in patients with asthma, and COPD patients experience more adverse effects than asthmatics. The side effects are dose related, resulting from systemic absorption, and include tremor, cramp, nervousness and tachycardia. To avoid these, the dose of salbutamol should be initiated at a low level and titrated according to clinical response. Administering the drug from a metered dose inhaler (MDI) and volume spacer produces fewer adverse effects and is as effective as a nebuliser.[1] A combination of MDI and spacer is the preferred drug delivery method for most patients with COPD.

Short-acting anticholinergic (ipratropium)

Ipratropium reduces reflux cholinergic bronchoconstriction, vagal airway tone and mucus secretion. The onset of action is slower than beta$_2$ agonists – it takes about one hour – but the bronchodilation is more sustained (up to eight hours) and at least as effective, and possibly more so.[3,4] Side effects include dry mouth, cough and blurred vision. If ipratropium is being nebulised, the mask must be fitted carefully or, ideally, a mouthpiece used to avoid the aerosol coming into contact with the eyes, which could cause glaucoma. Again, using an inhaler in combination with a spacer device will help to minimise adverse effects.[1]

Long-acting beta$_2$ agonists

The bronchodilator effects of long-acting beta$_2$ agonists (LABA) are similar to short-acting agents but their duration is around 12 hours. Two are licensed for use in COPD: formoterol and salmeterol. Each drug has a slightly different molecular structure which produces differences in the onset and duration of action. Clinically they both produce small improvements in lung function, reducing breathlessness and exacerbation rates.[5]

Long-acting anticholinergic (tiotropium)

Tiotropium has a duration of action of more than 24 hours and can be administered once a day.[6,7] It has kinetic advantages over ipratropium, producing improvements in lung function, reducing breathlessness, improving exercise tolerance and improving health status.[8,9] Tiotropium is well tolerated. The most common side effect is dry mouth and cough, which is seen in 15 per cent of patients.[10]

Methylxanthines

Methylxanthines (theophylline or aminophylline) have a small bronchodilator effect in COPD and may have anti-inflammatory properties. They may also increase diaphragmatic strength and affect mucociliary clearance.[11] The most common methylxanthine prescribed for stable COPD is theophylline but, because of its potential toxicity and significant interactions with other drugs, theophylline is recommended for use when other treatments have failed or when a patient remains symptomatic despite optimal bronchodilator therapy. To reduce the adverse effects, such as nausea, headaches and gastro-intestinal reflux, the dose of theophylline should start low and gradually increase according to symptoms and plasma levels. Plasma levels should be monitored after initiating therapy and then at regular intervals.

Great care is required in prescribing theophylline. Its clearance is affected by many factors, including cigarette smoking, viral pneumonia, heart failure and concurrent drug treatment. Caution is particularly required in the elderly because of differences in pharmacokinetics, the increased likelihood of comorbidities and the use of other medications.

Managing frequent exacerbations

Exacerbations are a major cause of hospital admissions for COPD, so efforts to reduce the number of exacerbations may lower the costs associated with hospital admissions. The following interventions may help:[1]

- All patients should be encouraged to have a pneumococcal vaccination and annual influenza vaccination.
- Long-acting bronchodilators should be used in patients who have two or more exacerbations per year.
- Patients should know how to respond to the first sign of an exacerbation. Starting courses of antibiotics or oral corticosteroids that they keep ready at home or adjusting their bronchodilator therapy may lead to reduced hospital admissions. The community pharmacist is ideally placed for monitoring the appropriate use of these medications.
- Add inhaled corticosteroids.

Corticosteroids

COPD, like asthma, is associated with

inflammation in the airways but the pattern of inflammation and the response to corticosteroids differs in each condition. Inhaled corticosteroids (ICS) do not appear to have any beneficial effects in patients with mild COPD. In patients with moderate and severe COPD – defined as FEV_1 less than 50 per cent predicted – ICS can produce benefit in terms of reduced exacerbation frequency and reduced rate of decline of quality of life.[12-14] They are recommended for patients with an FEV_1 of less than or equal to 50 per cent predicted, who are having two or more exacerbations requiring treatment with antibiotics or oral corticosteroids in a 12 month period.[1]

There is a potential risk of patients developing osteoporosis and other side effects from high doses of ICS so it is important that prescribing is limited to the above patients and the outcomes monitored. Routine use of oral corticosteroids is not recommended in stable COPD, but may be necessary in very severe patients who are unable to withdraw the oral steroids following an exacerbation. In this case the dose should be kept to a minimum.[1]

For pharmacological management of acute exacerbations see www.tinyurl.com/2zskos.[1]

Mucolytics

Mucolytics facilitate sputum clearance. Carbocisteine, mecysteine and the newly launched erdosteine are available for prescription in the UK. These drugs work in different ways – they all render the mucus less viscous but carbocisteine probably inhibits mucus secretion as well. Erdosteine reduces sputum volume, viscosity and elasticity, improves mucociliary clearance and may directly inhibit bacterial adherence to the mucosal cells and reduce colonisation.

Carbocysteine and mecysteine address long-term control of chronic productive cough in stable patients;[15] erdosteine is used specifically for treating this symptom during an acute exacerbation in combination with an antibiotic.[16]

Oxygen therapy

COPD is commonly associated with progressive hypoxemia. Oxygen administration of 15 hours/day reduces mortality rates in patients with advanced COPD.[1]

Specialists recommend long-term oxygen therapy for patients with a partial pressure of oxygen in arterial blood (PaO_2) of less than 7.3 kPa or between 7.3 and 8.0kPa and evidence of secondary polycythaemia, nocturnal hypoxia, peripheral oedema or pulmonary hypertension. Many patients who are not hypoxemic at rest worsen during exertion. Oxygen supplementation during exercise can prevent increases in pulmonary artery pressure, reduce dyspnoea and improve exercise tolerance.

Non-pharmacological management

Nutrition Many COPD patients benefit from nutritional assessment and advice. In the obese, weight reduction reduces energy requirements and improves the ability to exercise. Other patients may be malnourished or even cachectic.

Lung surgery A few patients who have emphysematous changes localised to one or two zones of the lung may benefit from lung volume reduction surgery (LVRS). The goal is to remove about 30 per cent of the most diseased tissues so the remaining healthier portion can perform better. LVRS can also allow the diaphragm to return to its normal shape, enabling more efficient breathing.

Smoking cessation Stopping smoking is the single most important intervention that alters the outcome in patients with COPD at all stages of severity.[17] Lost lung function cannot be regained, but the rate of lung function loss will slow to that of a non-smoker or non-susceptible smoker.

Pulmonary rehabilitation Pulmonary rehabilitation is a multidisciplinary programme of care individually tailored and designed to optimise physical and social performance.

Psychosocial interventions Psychological interventions include counselling, psychotherapy, social work input, sex therapy, family therapy and psychiatric help.

The whole patient

COPD is a common and important disease causing considerable morbidity. The total management is an exciting challenge for all involved. It is not just about treating the patient's lung disease but should include the management of many other associated problems.

References are available at www.dotpharmacy.com/respiratory

Anna Murphy, BSc MSc MRPharmS, is a consultant respiratory pharmacist at University Hospitals of Leicester NHS Trust.

Continuing Professional Development CPD

Act

- Review the causes, signs and symptoms of COPD in last week's Pharmacy Update. COPD and asthma present with many similar symptoms. Make sure you clearly understand this difference. The continuing education article for doctors at http://www.medscape.com/viewprogram/6143 is worth reading.
- The drugs used for asthma and COPD are also similar. Are there significant differences in drug treatment of these conditions? What is the place of systemic corticosteroids in the treatment of COPD? Is this significantly different from their place in asthma?
- Compare the cascade treatment for COPD with that for asthma. What are the differences, if any?
- The article places emphasis on the side actions/interactions of the methylxanthines. However, they are classed as Pharmacy medicines. Do you ever sell any OTC? If so, write a short note in your practice workbook on your rationale.
- Carry out an audit of all patients over, say, 60 years old to establish what percentage have had a pneumonia vaccination. At the same time find out if your COPD patients have had such a vaccination. If there are any who have not, encourage them to do so.

Evaluate

- When your next COPD patient presents (assuming that they are not housebound) talk to them about their condition in terms of quality of life. Can you think of any drug therapy that may improve it? How about other interventions – not smoking, reducing weight, oxygen? Take a holistic view. The article may help in this process.

Distance learning for pharmacists

Pharmacists using Pharmacy Update for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, C+D readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the April 7 issue, which will cover this week's CPP-accredited module, together with those in the March 10 and 17 issues.

These will cover:

- Ovarian cancer (1398)
- COPD part 1 (1399)
- COPD part 2 (1400)

A telephone marking service offers independent verification of results (see the monthly MCQ papers in C+D for details). If you wish to register for Pharmacy Update, please contact Pauline Sanderson on 01732 377269

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A Practical Approach...

Saturdays at the Update Pharmacy have been quiet since the local GP practice no longer opens and pre-registration pharmacist trainee Julia O'Reilly and occasional locum Mike Short are talking about how things have changed since Mike qualified more than 40 years ago.

"You know," says Mike, "there was no official obligation for pharmacists to keep their learning up to date but how things have changed. I only work the odd day, but I've got to do just as much CPD, with all the record-keeping, as any young full-timer.

"Also, doctors just prescribed drugs because they seemed to work. Now, as part of my CPD, I'm trying to get to grips with evidence-based medicine. I suppose they give you a pretty good grounding in it at college these days."

"Yes, I think I know pretty much what it's all about," replies Julia.

"That's good," says Mike, "There are some terms I don't understand. Can you tell me what p-value, number needed to treat (NNT), confidence interval and odds ratio mean?"

Questions

1. What are systematic reviews, p-value, number needed to treat (NNT), confidence interval and odds ratio? (Answer below)

CPD

This article can help in the following CPD competencies: G1a, G1e, C1a, C1b. See www.tinyurl.com/194zu

Chlamydia screening failing

The National Chlamydia Screening Programme may widen inequalities because of difficulties in targeting those most at risk, say NHS researchers.

A Health Technology Assessment of active postal screening for chlamydia found invitations were less likely to reach people in areas with a high proportion of minority ethnic groups, and uptake was lower in more deprived areas.

Women with the highest prevalence of infection were the most difficult to screen.

Combined opportunistic and active screening may be more successful and should be evaluated, they said.

The ClaSS study of nearly 20,000 men and women in Bristol and Birmingham found uptake rates of 39.5 per cent in women and 29.5 per cent in men.

Men should be targeted more actively, the team concluded.

• The government is currently trialling the use of pharmacists to increase access to free chlamydia screening. The results of a pilot scheme carried out in Boots stores in London are due in November.

For more information:
www.hta.nhsweb.nhs.uk

Should insulin glargine use widen?

Insulin glargine is both clinically effective and cost-effective, analysis of data from 300 general practices shows.

A study comparing analogues insulin glargine and insulin determir, found that insulin gargine markedly reduced the costs of diabetes related treatment.

In type 1 diabetes, a glargine-based regimen consistently reduced costs of insulin, reagents, hypoglycaemia rescue medication, pen delivery devices, and sharps. Similar results were found for type 2 diabetes, where a glargine-based regimen also reduced costs of treatment, with hypoglycaemia rescue medication falling by 34 per cent.

The findings contradict Nice guidance published in 2002 recommending that insulin glargine not be used routinely in patients with type 2 diabetes unless they needed assistance to carry out injections, suffered from recurrent hypoglycaemic episodes or who otherwise would need twice daily injections.

For more information:
Current Medical Research Opinion 2007; Suppl 1: 41-48 BJOG:

Nice considers ezetimibe with statins

Ezetimibe could be considered for use alongside statins in primary hypercholesterolaemia, a Nice consultation document states.

The treatment should be an option in patients inadequately controlled with statins or when higher doses can't be tolerated.

Monotherapy with ezetimibe is recommended for adults who have contraindications to statins or who suffer severe side effects.

A Practical Approach... this week's answers

1a) A systematic review in evidence-based medicine is the study of pooled clinical trials of a drug or drugs, designed to minimise any risk of bias. The objectives and methods of the review, and inclusion and exclusion criteria for trials are precisely defined. Appropriate statistical methods are used to pool data from trials (meta-analysis) and provide as accurate an estimate as possible of the efficacy and/or safety of the drug.

b) P-value is a statistical value calculated to confirm that a result obtained is unlikely to be the result of chance. The p-value used as the criterion of a 'statistically significant' result is 0.05 or lower, which means that there is no more than a 1 in 20 possibility that the result is due to chance.

c) NNT is the average number of patients that would need to use a drug in order to be treated more successfully than with the comparator in a trial, either another drug or a placebo, and is a measure of effectiveness. It is calculated by comparing the success rate in the trial with the two drugs (or drug and placebo). So, if a drug in a trial cured 80 per cent of the patients treated with it and a placebo appeared to cure 60 per cent of an exactly matched sample of patients, the difference in cure rate would be 80-60 = 20. The NNT would be 100 divided by 20 = 5, meaning at least five patients would need to be treated with the drug to ensure that one patient benefited.

d) Odds ratio (OR) is another measure of the relative effectiveness of a treatment, in comparison with another treatment or placebo. For example, in a systematic review, an odds ratio of 2.05 was calculated for sublingual NRT compared with no treatment. This means, in the trials, more than twice as many people gave up smoking using the active treatment compared with people who gave up using no treatment.

e) A confidence interval (CI) gives the limits within which the true value of the OR lies. It is usually expressed to a probability of 95 per cent (95 per cent CI). Using the above example, the 95 per cent CI for the OR was 1.62 to 2.59, meaning that it is 95 per cent likely that the actual number of people who gave up smoking in the trials using sublingual nicotine replacement tablets was between 162 and 259, compared with every 100 who gave up without treatment.

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Retinopathy is growing threat in young diabetics

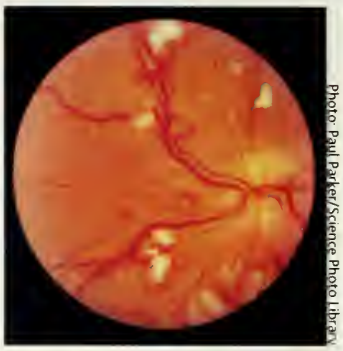


Photo: Paul Parker/Science Photo Library

Retinopathy and possible blindness are threatening many young patients with diabetes, according to a study presented at the Diabetes UK Annual Professional Conference.

The study of 103 young adults with diabetes revealed that more than half of those who failed to attend clinic appointments showed evidence of eye disease.

Coupled with official figures showing 26 per cent of diabetics between the ages of 12 and 17 years have not had an eye test during the last 12 months, this result suggests large numbers of young diabetics are threatened with blindness by the age of 40 years.

Diabetes UK chief executive Douglas Smallwood commented that screening needed to be targeted to the needs of young diabetics.

• The number of children under 15 with diabetes almost doubled between 1985 and 2004, say UK researchers, who also reported a five-fold increase in the under fives. Potential reasons include change in diet, reduced breastfeeding and changes in the environment.

Glitazones fracture warning

The American Food and Drugs Administration has issued a warning that an increased risk of distal limb fractures has been identified in women treated with the diabetes drug pioglitazone.

The FDA sent a similar warning to health professionals regarding rosiglitazone late last week.

The NHS prescribing advisers' weblog Prescribing Advice for GPs argued that fracture risk should be considered during medication reviews for female patients already on glitazones.

Also, in patients with poorly controlled type 2 diabetes, the pros and cons of hypoglycaemic agents should be considered and discussed with patients before beginning treatment.

PPIs reduce mortality

An updated Cochrane review has found that PPI treatment for peptic ulcer reduces mortality in those at the highest risk.

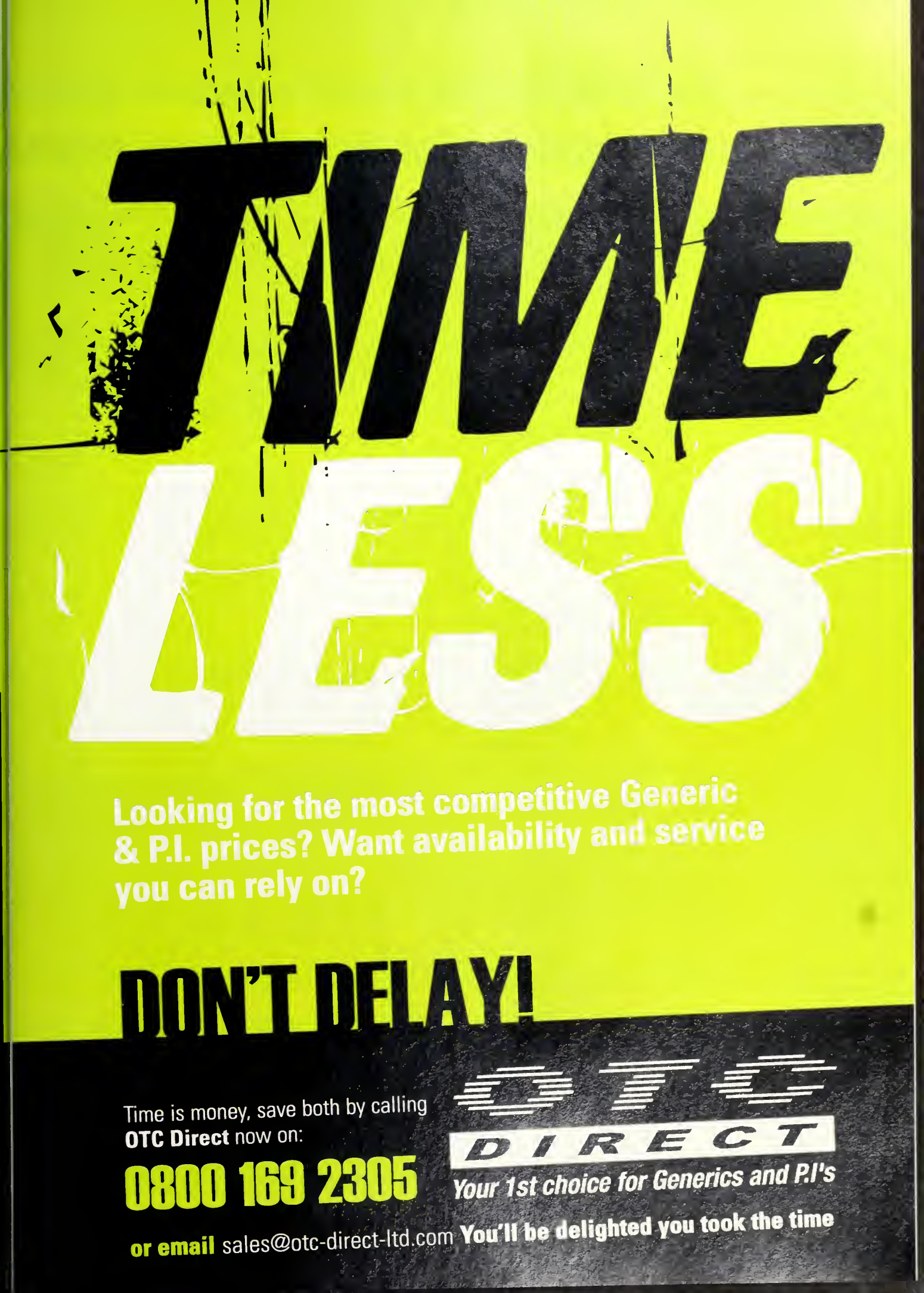
Researchers reassessed the evidence in light of a number of new trials and also concluded use of a PPI reduces incidence of ulcer bleeding and the need for surgery.

They analysed 24 trials with 4,737 participants comparing oral or intravenous PPIs with placebo or an H_2-receptor antagonist for peptic ulcer bleeding. Rebleeding episodes were found to be reduced by 51 per cent and the need for surgery was cut by 39 per cent.

For more information:
Mayo Clin Proc 2007; 82: 286-96

In brief

Prolonged treatment in children with inhaled corticosteroid treatments at high doses risks systemic side effects, a review in the latest MeReC Extra bulletin has warned. In a Scottish study, 42 per cent of children prescribed above the licensed dose exhibited adrenal suppression. http://tinyurl.com/yproj4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Power of the pomegranate

Health Perception has harnessed the antioxidant properties of the pomegranate for its latest launch, Super Antioxidant.

The fruit is said to provide the highest levels of polyphenol antioxidants, which can help lower bad cholesterol.

Also included in the formulation are glutathione, vitamins E and A, selenium, grape seed and tomato extracts. Packaging mirrors the company's 'Jump for joints!' campaign and the product will replace the existing Antioxidant Plus tablets.

Consumer advertising will run during April and May and trade advertising by the company is ongoing.

Price: £6.99/30

Product info:
Health Perception
Tel: 01252 861454
www.health-perception.co.uk

Fortuna's first babycare steps

A babycare range has been launched by Fortuna Healthcare.

Designed to provide comfort and safety to infants during the various stages of growth, the range includes teethers, medicine feeders, safety products and grooming products.

Teethers come in various coloured water and gel-filled variants, which can be refrigerated before use. They feature uniquely shaped handles and have textured surfaces to soothe baby's gums during teething, says Fortuna.

Easy-to-read graduations on the medicine feeders allow for easy and accurate dispensing, says the company. A medicine syringe includes a rubber shaped teat for easy dispensing while the training toothbrush features an easy-grip handle with soft bristles and is suitable up to the age of three years. The range further includes grooming products and a nasal aspirator with travel cap. Prices start from 69p.

Product info:
Fortuna Healthcare
Tel: 020 8805 7805

The eyes have it online

A new-look website for the ICaps dietary supplement has been unveiled by Alcon.

With "a holistic approach" to eye health, the site offers advice to consumers on taking better care of their eyes.

Visitors to the site can learn how to make kale stew in the recipe section which provides lutein and antioxidants from the main ingredient while carrots contribute vitamin A and beta carotene. For the information hungry, an 'Ask an expert' section offers the chance to pitch eye health questions to optometrist Dr Frank Eperjesi.

Product info:
Alcon Laboratories
Tel: 01442 341234
www.icapsinfo.co.uk

Test for allergies with Menarini

An allergy testing device has been launched by A Menarini Diagnostics. The ImmunoCAP Rapid confirms the presence of IgE antibodies to a range of allergens via a blood test.

Two versions are available covering symptoms of wheeze and rhinitis in children and asthma and rhinitis in adults. A third kit is due to launch later in the year testing for allergens associated with eczema.

The kits produce results in 20 minutes and can be used on pharmacy premises. Pharmacists could offer the service independently or link up with GPs or the local PCT, suggests the company. The cost to customers for the service is £49, with a trade price of £30.

Product info:
A Menarini Diagnostics
Tel: 0118 944 4100

READER OFFER: Menarini is offering packs of three devices free to the first 50 C+D readers to call the number above

TV return for menopause test

The Novogen Menopause Test is appearing on television in its second TV ad campaign.

The product has sold at three times its predicted level since its launch, reports Novogen.

The 'Are You in the Dark About Menopause?' campaign will be seen on GMTV during Lorraine Kelly's LK Today show.

More than 99 per cent accurate, the test measures levels of follicle stimulating hormone to indicate the body's transition to menopause.

Product info:
Novogen
Tel: 0845 603 1021

Products advertised on TV next week

Buscopan: GMTV
DulcoEase: C4, five, GMTV, Sat
Gaviscon Double Action: All areas
Imigran Recovery: B, G, Y, C, M, TT
Just for Men: All areas
Lucozade Sport: Sat
Milton: All areas except five
Novogen Menopause Test: GMTV
Poligrip: All areas
Sensodyne: Sat
Sensodyne Pronamel: Sat
Vagisil: All areas
PharmaSite for next week: Ibuleve – Windows, **Ibuleve** – In-store, **Otex** – Dispensary
Pharmacy channel: Vega Nutritionals, Aveeno

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

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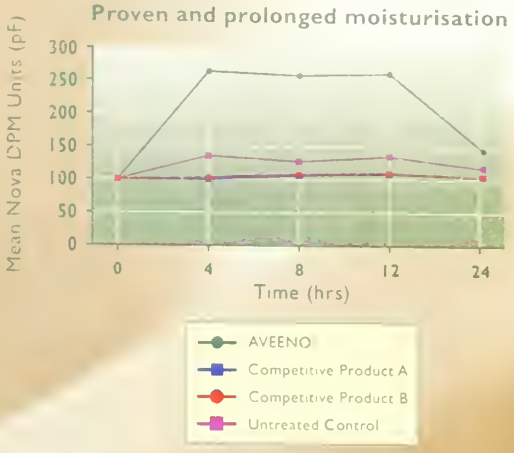

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Locum at large

Time for a rethink

Let's take a fresh look at CPD, says our locum columnist

Ever since the RPSGB introduced continuing professional development, it has been the great unloved duty that we have had to perform.

Mention CPD to anyone and the response is almost entirely negative – I literally do not know more than a few people who have a good word to say for it, as it can be a complete and utter bind to have to go through the laborious process of completing a CPD entry and posting it for someone to assess eventually on behalf of our lords and masters.

Not only do pharmacists have difficulty in finding the time to devote to CPD on top of their present busy workload and extensive travelling (for locums), to say nothing of family pressures, but there is a general feeling that the CPD format is wrong – one that is too structured, and does not serve the requirements of the membership.

I attend as many CPPE events as I can and the enthusiasm for them and the praise for the value of completing any of the excellent modules are in stark contrast to the universal negativity expressed at those meetings in regard to CPD.

I read once that little more than half the membership had performed any CPD in the first year and I cannot think the figure would be much higher in the second. Obviously the Society will be keeping a watchful eye but I wish it would listen to the membership in assessing whether anyone is getting as much value out of CPD as the Society would wish.

Any new initiative is bound to take a while to bed down but CPD has been going long enough for the Society and membership to see if it is achieving the purpose for which it was set up. The time for an assessment of the progress of CPD in actually raising professional skills in the profession is surely now due as, in my experience, not only do pharmacists accept the need for skills updating, but most actually want to keep up to date and abreast of developments in treatment and patient care.

Many pharmacists feel CPD is a burden rather than a useful tool in raising standards. That surely cannot be right. Has anyone ever consulted the membership on what it actually requires of CPD rather than having the Society's model imposed upon it?

Also, CPD tends to ignore the huge amount of reading that the average pharmacist undertakes. Until a couple of years ago, my office at home contained very little pharmaceutical literature. Now I have a cupboard bursting with papers, magazines, DVDs and articles in case they might be useful, to say nothing of MUR literature by the sack full. I read C+D from cover to cover and there now appear to be numerous magazines in every pharmacy that I visit, all of which I attempt to read.

Indeed, I sometimes think I am suffering from information overload, so great is the sheer volume of information to which I now have access. My wife is always complaining that I am more married to pharmacy than to her. Little of this appears in my CPD.

Perhaps Lambeth could give us some indication as to its thinking on the progress of CPD, and engage in constructive debate with the membership for it is in all our interests that pharmacists should be as up to date in our field as other health professionals are in theirs.

My wife is always complaining that I am more married to pharmacy than to her

Independents' day

Keele University had 42 students on its first IP conversion course, which involved 50 hours' flexible training for previous students of its supplementary prescribing course

Pharmacists can now study for a practice certificate in independent prescribing, which gives them a great opportunity to move the profession and services forward. Jane Ellis reports

Independent prescribing marks a turning point for the pharmacy profession. Community pharmacists now have the tools to provide even greater packages of care for their patients. The first pioneers have qualified and are able to prescribe any medicine from the BNF (initially, except controlled drugs) for any medical condition within their competence.

Clive Jackson, head of the National Prescribing Centre, says: "IP is a real watershed for pharmacy in moving the profession and services forward. Pharmacy has been waiting for this for a long time and it will give the profession full flexibility to do a lot of good for patients. Now it's a question of how pharmacists persuade commissioners and providers of independent prescribing services that they are the right people to do it."

He expects there will be around 12,000 non-medical prescribers in England and Wales by the end of the next financial year. Of these, more than 10,500 will be nurses, mainly because the Nurse Prescribers' Extended Formulary was expanded in May 2005 and there are 600,000 nurses in the UK compared with 40,000 pharmacists.

"IP will allow pharmacists to use their skills in a significantly different way and will suit the service environment. In addition, pharmacists with special skills will be able to develop new services with their independent prescribing skills," he adds.

Diagnostic skills

Mr Jackson believes the diagnostic training provided by the IP conversion course will be sufficient for pharmacists with special skills in coronary care, for example, but those involved in more general prescribing might need additional support.

"IP pharmacists acting independently need diagnostic skills if they are going to provide treatment in a convenient and cost-effective way," he says. "They'll all need diagnostic skills, but some will need more than others. The whole culture of pharmacy is not hands-on. It will be an issue of changing the mindset of pharmacy in the future. There's more hands-on work than there used to be, but fundamentally pharmacists are not trained as diagnosticians."

Dave Barton, co-ordinator of advanced clinical studies at the University of Wales in Swansea, is adamant that none of the IP conversion courses will provide adequate diagnostic training. "In my opinion, an independent prescriber is a healthcare professional who can undertake a systematic health history of a patient, a full and appropriate physical examination, come to an appropriate differential diagnosis and initiate appropriate clinical management," he says. "They need extensive training in pathology, pharmacology, making health assessments, consultation skills and time in practice developing these skills." ▶

> Every health professional is drowning in a sea of information

Working with GPs

Mentors or designated medical practitioners (DMP) should be on hand both during and after training to offer peer support and enable independent prescribers to gain extra diagnostic experience.

However, it is not always easy to find a DMP, particularly since GPs have been swamped by requests for help. Because GPs are not financially rewarded for offering this assistance, much of the support so far is being provided on a goodwill basis. However, Mr Jackson says by and large GPs are keen on skill mixing and reasonably positive about becoming DMPs, even though there has been some resistance.

It is a misconception that the training will provide a pharmacist with all the appropriate knowledge in any case. It provides the principles and processes of good prescribing, but this is ongoing and needs to be maintained.

"Every health professional is drowning in a sea of information and it will be a question of mastering this," Mr Jackson says. "You have to learn strategies to target information and access it in the right way. CPD applies to all pharmacists and is a specific element in IP, so it will become increasingly important."

Any pharmacist who wants to get involved in independent prescribing will also need to be clear about what they want to achieve, which should be improving the lot for patients, and in the process becoming more efficient and cost-effective in their prescribing. "IP will certainly provide greater job satisfaction, but it's primarily there to improve patient care," says Mr Jackson.

Jane Portlock, course leader at the University of Portsmouth, which is awaiting approval from the RPSGB, agrees that IP pharmacists will need to have a good working relationship with a GP and in turn the GP will have to see a role for the pharmacist within his/her practice setting.

"It's no use just getting someone to supervise you for the course, you also need to have a clear plan for how and where the prescribing qualification is going to be used," she says.

The funding

There are also many issues about funding that have yet to be resolved. Angela Alexander, senior clinical lecturer at the University of Reading, suggests students put up a good business case for independent prescribing when applying for funds. She advises them to identify the clinical need and

benefit to the patient and make a note of 20 patients where it would have helped if they could have prescribed for them. She also suggests they seek the views of patients, medical and nursing staff; and have a statement of support from the local independent prescriber who supervised them for their learning in practice.

While funding will probably be through NHS trusts for pharmacists employed by the NHS, this is by no means certain with the ongoing reconfiguration of strategic health authorities. For community pharmacists, funding may be available via practice-based commissioning, but again this is not clear. Some course leaders suggest pharmacists approach the prescribing lead at their PCT to support their application and for assistance in identifying a suitable mentor.

Providing a locum to keep the existing business going while the pharmacist is being trained to be an IP is also an issue for an independent pharmacy. Even though the multiples might have more opportunities to put pharmacists through IP training, everyone will have to look carefully at the direction in which they want to take their businesses. "Getting funding is not easy, no matter how you approach it, or what type of pharmacy business you are from," says Mr Jackson.

Independent prescribing is, according to RPSGB president Hemant Patel, "the most significant professional development opportunity for pharmacists that we have seen in a generation". It offers pharmacists great opportunities to demonstrate what they can do for the local community while improving their job satisfaction. Let us hope that it fulfils its promise. ▶

Mahesh Sodha – Case Study 1

Mahesh Sodha, a pharmacist at Colecross Pharmacy in Chelmsford, hopes to start an IP conversion course at King's College, University of London, which has RPSGB approval. He says the difference between supplementary and independent prescribing is that independent prescribing will mean taking full responsibility for the assessment of the patient. "In this respect, my weakest area is clinical examination skills, which I have learnt from GPs on the job," he says.

Mr Sodha qualified as a supplementary prescriber in 2004 and started running clinics for diabetes, hypertension and dyslipidaemia. He has been running a weekly clinic at a two-branch surgery of six GP partners, managing some 300 patients. Since September 2006 his clinical management plan has been modified to enable him to manage erectile dysfunction, weight management and chronic kidney disease. While this clinic ended in November last year owing to lack of funding, Mr Sodha is now running a similar clinic at another practice in Chelmsford over the next six months.

Once he has an IP qualification, Mr Sodha says he will be able to prescribe for many minor ailments while patients are consulting him about their long-term conditions. He says finding a DMP was not difficult because he has always worked closely with clinicians and has had an excellent professional relationship with a dozen or so GPs locally. "I have been very lucky in having a very experienced DMP who is interested in and trains GP registrars. The key here is having a relationship where there is mutual respect for each other's skills," he says.

David Thompson – Case Study 2

David Thompson, a pharmacist at Boots in Bournemouth, has been lucky in that his employer agreed to fund his time away from store while he attended the Bath University supplementary prescribing course. The course was changed halfway through to build in the extra elements for independent prescribing, which means he will qualify as an independent prescriber.

In March or April he will start admitting patients to a local in-patient drug and alcohol addiction unit. He will be required to physically examine them prior to admission to ensure that they have no hidden problems that require referral and may be safely medically treated. He will then prescribe for them during their stay in the unit.

Having been a health centre pharmacist since April 2002, Mr Thompson has worked closely with GPs and practice staff. "The senior partner kindly offered to help, though I don't believe either of us knew the extent of his commitment when we started. The doctor in charge of the local addiction services has also mentored me in the specific field of addiction," he says. "I therefore had two mentors, not one. I am very grateful to both of them for their commitment to me, without which the whole thing becomes impossible."

The competencies he will learn will be transferable from addiction to other areas of his work and Mr Thompson has already found that he approaches requests for over-the-counter advice in a different way. "I am much more likely to ask more detailed questions and my consultations have increased in length," he says.

The IP training has also given him more confidence to ask questions and to think beyond the safety of selling a particular product to what the diagnosis might be. It has also improved his job satisfaction. "Without doing the course I think I might have gone nuts before retirement. I have worked in community pharmacy for 22 years and there's only so much dispensing you can do! A prescribing role gives me a patient-centred clinical approach to my work that I find is missing with the pure mechanics of dispensing medicines."

Nader Siabi– Case Study 3

Nader Siabi, a Canvey Island pharmacist with supplementary prescribing experience and a teacher practitioner at the University of Hertfordshire, says the university has completed its internal validation of the IP conversion course it hopes to offer and has applied to the RPSGB for accreditation.

"I think long-term that the supplementary prescribing course will be for physiotherapists and other health professionals, with pharmacists and nurses becoming the independent prescribing experts," he says.

Mr Siabi suggests that pharmacists seeking to become IPs should identify the area of treatment that they want to specialise in – such as asthma or COPD – and then approach a local GP to become their DMP. "If you present yourself as a pharmacist with expertise, the GP will realise that patients with asthma or COPD could be sent to you and therefore reduce their workload and they'll be very happy to be your mentor," he says.

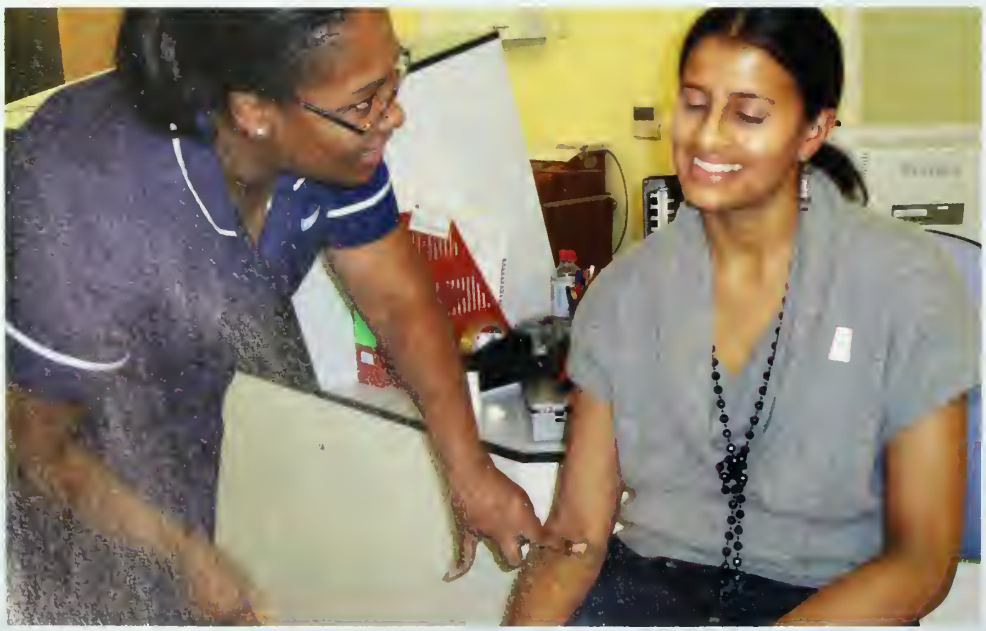
Mr Siabi has no difficulty with making a diagnosis. "I already have a diploma in respiratory diseases and COPD and such training gives you the competencies to make a diagnosis. Your confidence grows with each patient that you see. You get better and better by taking courses that improve your level of competency. Fight your way into the surgery and find your patients, then you'll build the expertise."

Where to study for a practice certificate in IP

• The University of Reading's IP conversion course comprises two study days and two days of practical experience, and will initially be offered two or three times a year.

• The University of Keele trained the first pharmacist to be awarded a practice certificate in independent prescribing. Beth Hird, senior practice pharmacist at Nottinghamshire County Teaching PCT, successfully completed Keele's conversion course in January. Ms Hird has built up a competence in prescribing for patients with asthma using supplementary prescribing and will take an independent prescriber role in this area.

• Keele had 42 students on the first cohort of its IP conversion course. The university offers a flexible 50-hour course to be undertaken within six months for previous students of its supplementary prescribing course.



• Bath University's first conversion course consists of 10 face-to-face days including the final assessment, with two days of practical experience. Twenty six pharmacists at Bath have been awarded IP status so far.

• King's College London offers a four-day conversion course. Three of these days are self-directed learning, with two 7.5-hour days undertaken in practice under the supervision of a DMP.

• Brighton, Leeds, Robert Gordon and Sunderland universities have received approval to offer IP conversion courses. Further providers are at varying stages of the approval process and details are available at www.rpsgb.org

• Five pharmacists have registered as independent prescribers with the Pharmaceutical Society in Northern Ireland and the Centre for Postgraduate Pharmaceutical Education and Training (NICPPET) has gained full accreditation to run the UK's first full IP course.

• By this autumn there will be 150 non-medical IP prescribers, a mix of pharmacists and nurses who currently hold supplementary qualifications, operating in Wales.

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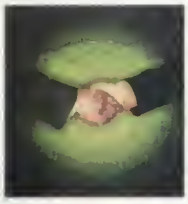

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Crouching Tiger, Hidden Stoate

Dr Howard Stoate MP, chair of the All-Party Pharmacy group, has been harbouring a secret pet project which C+D can exclusively reveal for the first time – his Tiger.

No, it's not a feline member of an endangered species, but a custom-built sports car that would make the gangsters of Pimp My Ride explode in a cacophony of high-fives.

"I couldn't possibly comment!", says Dr Stoate, when asked how fast it goes. "Not without being investigated by the Met!"

Dr Stoate spent a year ("sometimes I'd get home from work at 10pm and work on it till midnight") and around £5,000 on his "passion", fusing second-hand parts of Fords, VWs and Toyotas to name but a few, in his garage, while on his way to creating the motoring beast you see before you.

We'd say the Tiger makes Dr Stoate the fastest GP around. But what next for the budding welder extraordinaire? "I'd love to do an aeroplane. But that's a long-term vision. I'll have to wait until I have more time." Watch this space.

Appointments

C+D has appointed Tom Hawkins as online editor. Tom will take charge of www.dotpharmacy.com as C+D looks to further develop its online presence.

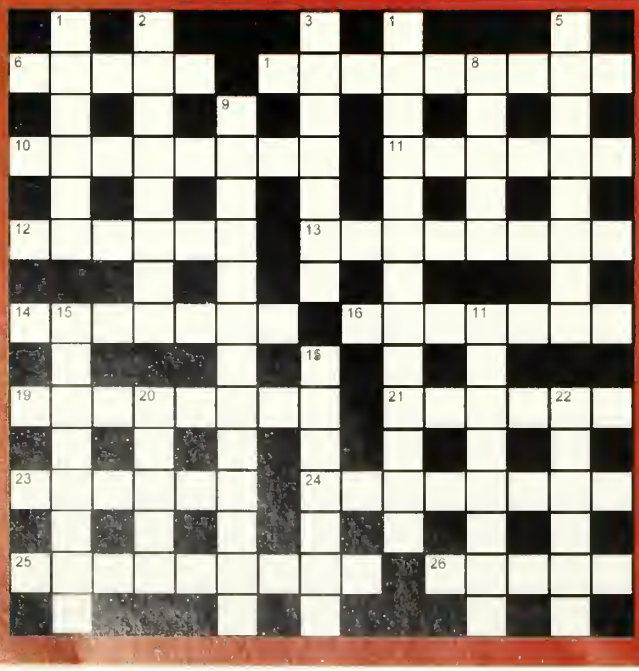
Tom was formerly news editor on Printing World and has most recently been working freelance for C+D, as well as contributing features to Daltons Weekly and developing online content, including video features, for daltonsbusiness.com

Win a C+D mug with our BIG movie crossword!

Win one of these exclusive thermal mugs by sending your correct crossword entry to C+D Crossword, Riverbank House, Angel Lane, Tonbridge TN9 1SE by Tuesday March 27 or fax to 01732 367065. A lucky winner will be pulled from the hat and announced in next week's issue.

Name _____

Telephone number _____



Clues Across

6 The Bridget from Single White Female (5)
7 Sci-fi adventure with Ewan McGregor and Scarlett Johansson (3,6)
10 He played Alan Grant in Jurassic Park (3,5)
11 I Know What You Did Last _ , horror film (6)
12 The Merchant of _ , Shakespearean cinema adaptation (6)
13 Director who won an Oscar this year for The Departed (8)
14 _ Alive, sequel to Saturday Night Fever (7)
16 _ Sunshine of the Spotless Mind, it starred Jim Carrey and Kate Winslet (7)
19 Martial arts legend – star of Enter the Dragon (5,3)
21 In which Kathy Bates is James Caan's number one fan (6)
23 Eyes Wide Shut turned out to be Stanley Kubrick's final opportunity to do what? (6)
24 _ Girl, it featured Nicole Kidman as a mail-order Russian bride (8)
25 Classic biker movie from 1969 starring Dennis Hopper (4,5)
26 The Hitchhiker's _ to the Galaxy, eccentric sci-fi film (5)

Clues Down

1 Casino _ , spy film starring Daniel Craig as 007 (6)
2 The Bourne _ , Matt Damon thriller (8)
3 _ _ King of Scotland, cinema release based on Idi Amin (3,4)
4 Sci-fi foray similar in theme to The Red Planet (7,2,4)
5 It describes the setting for movies such as The Abyss and Sphere (8)
8 The Silence of the _ , much-acclaimed movie (5)
9 Roger Moore's first outing as James Bond (4,3,3,3)
15 The _ , in which Tom Hanks is stuck at JFK (8)
17 Film that paired Jackie Chan with Chris Tucker (4,4)
18 Baby Flintstone in both the series and the movie (7)
20 _ Chase, he played Clark Griswold in the Vacation films (5)
22 Hotel _ , real-life drama starring Don Cheadle (6)

CONGRATULATIONS...
To Ryan Catney at Dundees Chemist in County Antrim, Northern Ireland. He is the first winner of our BIG movie crossword, and a coveted C+D mug is in the post

Last week's answers across
8. Apollo **9.** Charlie's **10.** DiCaprio **11.** Grinch **12.** Pierce Brosnan **14.** Knights **16.** A Series **19.** Chris O'Donnell **23.** Dragon **24.** Actually **25.** Eastwood **26.** Crenna

Answers down
1. Spain **2.** Clearing **3.** Horror **4.** October **5.** Bad Girls **6.** Plains **7.** Wes Craven **13.** Anchorman **15.** Thornton **17.** Reloaded **18.** Bogarde **20.** It Gets **21.** Notice **22.** Along

Over to you...

Seen anything wacky in the weird and wonderful world of pharmacy?
Let us know, and your name could appear here in Out of Hours.
Email wyin-poole@cmpi.biz, tel 01732 377466 or write to: Out of Hours, C+D, Riverbank House, Angel Lane, Tonbridge TN9 1SE.

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